MEDICAID/PEACHCARE FOR KIDS PROVIDER
Instructions for Change of Information Form

This form is used to make modifications to provider information maintained in the Georgia Medicaid/PeachCare for Kids (M/PCK) provider system. Only one provider number may be modified per form. Please complete the section pertaining to your request. This form **CANNOT** be used for a Change of Ownership. **A Change of Ownership requires that a new application for enrollment be submitted.**

Please note: A change to group practice information under GBHC that applies to all GBHC providers within the group only requires that one form be submitted on behalf of the group practice.

Check the type of change being reported.
Enter the Georgia Medicaid/PeachCare for Kids Provider Number for which changes are being made.

1. Current Provider Identification (Required)
Complete provider's full name or business name as it is currently on file with Georgia M/PCK. Enter the provider's social security and/or Tax Identification number as applicable.

2. New Business/Name Information
If the provider is reporting a name change, complete applicable changes to the individual, organization or group, or Payee name in the appropriate section. For any name change the provider must submit a certified copy of the legal document(s) showing the old and new names. For a change of payee name, the provider must submit an amended W-9 or other official correspondence from the IRS showing the new name and tax identification number related to the new name.

3. New Address/Telephone Number Information
- Check "Administrator Address" if the provider is changing the contact information for the Office Manager, or other responsible party for this provider. A Post Office Box is acceptable as the administrator's address.
- Check "Mailing Address" if the provider would like correspondence to go to an address other than the mailing address that is currently on file. A Post Office Box **is** acceptable as the mailing address.
- Check "Payee Address" if the provider would like payments to go to an address other than the payee address that is currently on file. A Post Office Box **is** acceptable as the payee address. A change in payee address must be accompanied by a W-9 or other official correspondence from the IRS showing the new address related to the current tax identification number.
- Check "Practice Address Change" if the provider is making a change in the physical address of the practice. A Post Office Box **is not** acceptable as the physical practice address. A change in physical address must be communicated to GBHC and a site visit performed for continued participation in GBHC.

4. Office Manager
An Office Manager is the appointed person who has the authority to enroll as well as make changes and/or updates to the provider's status and to commit the practice/location to Medicaid or other health care program laws. Complete this section if the provider wishes to delete the currently listed office manager or to add a new office manager.

5. GBHC Provider Information Change
If a GBHC provider wishes to change pertinent information related to practice type, languages spoken, accepting new patients status and age range of patients accepted, please use this section.

6. Medicaid Provider Number Deactivation Information
If the provider wishes to deactivate their M/PCK program billing number or participation in a particular M/PCK program, provide the provider number or category of service description and the reason for deactivation.

7. Effective Date of Change(s) (Required)
Report the date on which all listed changes are effective.

8. Attestation Statement (Required)
Sign and date this form attesting to the accuracy of the requested changes. If changes are being reported on an individual provider, then that individual must sign this form. If the changes are being reported for an organization or group practice, an authorized representative of the organization or group practice must sign this form to confirm the requested change(s).

If you have any questions regarding this form or enrollment requirements, please contact the ACS Provider Enrollment Unit at (404) 298-1228 or (800) 766-4456. Return this form with any necessary attachments to:

ACS Provider Enrollment Unit
P. O. Box 88030
Atlanta, GA 30356

Fax: 866-309-0935

MEDICAID/PEACHCARE FOR KIDS PROVIDER
Change of Information Form

Type of Change (Check all that apply)	☐ Medicare Information ☐ Address Information ☐ Telephone Number	☐ Legal Name ☐ Payee Name ☐ Taxpayer I.D.	☐ Office Manager Information ☐ GBHC Provider Information ☐ Deactivation of Participation

Medicaid/PeachCare for Kids Provider Number (One provider number per form):

1. Current Provider Identification (Required)

Name: First	M.I.	Last	Jr., Sr., etc	MD., DO., etc
Business Name:				
Social Security # (if applicable)	Taxpayer I.D. #:	UPIN:	NPI	

2. New Business/Name Information

A. Individuals Only

Name: First	M.I.	Last	Jr., Sr., etc	MD., DO., etc
Doing Business As Name:				
Social Security # (if applicable)	Taxpayer I.D. #: (Attach W-9)	Medicare Provider #		

B. Organizations or Groups Only

New Legal Business Name:	DBA Name:
C. Payee Name:	Taxpayer I.D. #: (Attach W-9)

3. New Address/Telephone Number Information

☐ Administrator Address (P.O. Box acceptable); ☐ Mailing Address (P.O. Box is acceptable); ☐ Payee Address (P.O. Box is acceptable)
☐ Practice (Location) Address (P.O. Box is not acceptable)

New Address Line 1:			
New Address Line 2:			
New City:	New State:	New Zip Code:	New County:
New Email Address:	New Web Address:		
New Telephone Number:	New Fax Number:	New After-hours Number: (GBHC Providers should attach documentation)	

4. Add / Delete Office Manager

A. Add Office Manager:

Print Name and Title:	SSN:	DOB

B. Delete Office Manager:

Print Name and Title:

5. GBHC Provider Information Change

A. Practice Type: ☐ Male only ☐ Female only ☐ Both **Age Ranges:** _____ **to** _____

B. Languages Spoken:

C. Accepting New Patients: ☐ YES ☐ NO

6. Medicaid Provider Number / Category of Service Deactivation

Medicaid Provider Number:	Reason for deactivation request? (Attach additional sheets if necessary):
COS to deactivate:	

7. Effective Date of Change(s) (Required)

This change/these changes are effective as of (MM/DD/YYYY):

8. Attestation Statement (Required)

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of material information may subject me to liability under civil and criminal law.

Provider's Name (print):	Title:
Provider or Office Manager's Signature:	Date: